ALERUS

REIMBURSEMENT FORM

DEPENDENT CARE

Employer	Name	Social Security No.	Email Address

Address (Street, City, State, ZIP)	☐ Check if new address

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Dependent Name	Age	Amount of Expense	Provider Name	Provider Tax ID	Dates of Expense
		$			to
		$			to
		$			to
Total Requested		$	**Provider Signature**[1]		

1 Provider signature may be provided in lieu of a receipt.

INDIVIDUAL PREMIUM REIMBURSEMENT (FOR ICHRA/EBHRA BENEFITS ONLY)

Policy for (self, spouse, family)	Amount of Premium	Dates of Expense	Name of Carrier
	$	to	
	$	to	
	$	to	
	$	to	
Total Requested	$	**Important:** Please attach proof of premium cost incurred such as a copy of your itemized bill or contract from the insurance carrier. Copies of checks are not considered acceptable proof of an expense.	

I certify that the information contained in this form is to the best of my knowledge true and correct, and each item of expense is eligible for reimbursement. I also certify that all items requested to be reimbursed comply with the Company's Flexible Spending Account plan and such items have not and will not be reimbursed by any other plan or program. I certify that such items will not be deducted or taken as tax credits on my personal Federal or State Income tax returns for any year. I also understand if I receive money from my Flexible Spending Account for expenses that are not eligible, I may be liable for FICA, Federal, and State Income taxes on those amounts.

Employee Signature _____ Date _____

Return this form to:

Alerus Retirement and Benefits
Attn: Health Benefits Department
P.O. Box 64535
St. Paul, MN 55164-0535

Phone: 877.661.4727
Fax: 507.373.2409
Web: alerusrb.com

Do not complete this form for purchases made with your Alerus Health Benefits card.